Ashley Down Care Home Limited

Ashley Down Nursing Home

Inspection report

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Ratings

Overall rating for this service	Requires Improvement

Is the service safe?	**Requires Improvement**
Is the service effective?	**Requires Improvement**
Is the service caring?	**Requires Improvement**
Is the service responsive?	**Requires Improvement**
Is the service well-led?	**Requires Improvement**

Summary of findings

Overall summary

The inspection took place on 20 and 21 February 2018. The inspection was unannounced on the first day. We told the provider and manager when we would return to complete the inspection.

Ashley Down Nursing Home is a 'care home'. People in care homes receive accommodation and nursing and personal care as a single package under one contractual agreement. CQC regulates both the premises and the care provided, and both were looked at during this inspection. Ashley Down Nursing Home provides accommodation and support for up to 19 older people. There were 11 people using the service at the time of our inspection. Some people were unable to communicate verbally with us. People had varying needs including diabetes and Parkinson's disease and some people were living with dementia. Some people required the use of a hoist to help them to move from their bed to a chair and vice versa and others required two staff to assist them to move around. Six people were cared for in bed due to their frail health.

A registered manager was in post. The registered manager was also the registered provider. A registered manager is a person who has registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'. Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the service is run. A new manager was in post who had not yet registered with CQC, this manager was present throughout the inspection, providing the information we requested.

At our last inspection on 4 and 7 July 2017 we found breaches of Regulations 9, 11, 12, 17, 18, 19 and 20A of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Five breaches had continued since the previous inspection relating to, person centred care and the lack of meaningful activity to avoid social isolation; people's basic rights and consent to care and treatment; the management of risk in relation to individuals' safety and the safety of staff; the management of the deployment of staff to ensure safe staffing levels and the management of effective systems to ensure the quality and safety of the service. Two further breaches were identified relating to safe recruitment practices and the display of the previous inspection ratings in a prominent place. We placed the service in special measures for the second time and initiated action against the provider. This inspection took place to check that the provider had made improvements in the areas that required improvement.

At this inspection, we found the provider had made improvements within the service, although further

improvements were required and work was still in progress.

We told the provider they must not admit any new people into the home following the last inspection in July 2017. This meant the provider and the new manager were able to spend time improving the quality and safety of the service for the existing people living there.

People and their relatives told us they received care that was safe, effective, caring, responsive and well led.

At this inspection, we found that sufficient improvement had not been made to the assessment used to determine the numbers of staff required to provide the level of care people needed. Staff did have the opportunity to meet with their line manager on a regular basis to discuss work related issues.

Sufficient improvement had not been made to the recruitment processes. Robust checking had not always been employed when assessing the suitability of new staff to provide care and support to people living in the service.

The evidence was not available to show that staff had received the training and updates required to carry out their role providing care and support to people. Registered nurses were not provided with the opportunities to continuously develop their skills in order to maintain and improve their professional role. New staff were not provided with the induction, training and development at the start of their employment in order to succeed in their role.

Some elements of medicines management needed improvement in order to provide a safe and effective service when administering prescribed medicines.

Improvements had been made to the safe management of individual risks to prevent harm. Record keeping had improved, staff recorded the time they spent with people and what they did so their care could be monitored. Accidents and incidents were recorded well and monitored by the manager to prevent further incidents. More detailed plans were now in place to assist people to evacuate the building or keep them safe in an emergency.

Improvements had been made to the assessment and support of people who lacked the capacity to make their own decisions, although further work was underway by the new manager to improve this area further.

Referrals to appropriate health care professionals was now better evidenced. A consistent approach was not taken when monitoring the blood sugar of people with diabetes. We have made a recommendation about this. An assessment tool used to monitor the risk of malnutrition was erroneously scored, showing a score that was not correct. We have made a recommendation about this.

The provider had not responded in a timely manner to requests from registered nurses to purchase a new camera in a timely manner to support them to evidence the progression and treatment of appropriate wound care.

Improvements had been made to the person centred approach within care planning, showing information crucial to people's care was recorded in their care plans. Further work was needed to embed the information provided in care planning into the daily practice of the staff such as ensuring practice was not routine led. Although people were involved in decisions about their care, and told us this was the case, this was not always evidenced in the records.

People had the opportunity to discuss their wishes at the end stages of their life if they wished. People's cultural and spiritual needs were recorded, however this needed further work to ensure it was relevant and assumptions weren't made.

Some concerns were found around maintaining people's privacy and dignity, however, this was not a wider issue. People and their relatives told us their privacy was respected by staff.

Although improvements had been made to the quality and safety of the service provided, further action was needed through sustained management and leadership to ensure the progress continued. Monitoring and auditing systems were now used to better effect to inform the improvements required and the action to be taken. However, the systems were still in their infancy and needed to embed to evidence they were sufficient to ensure progress could be maintained.

People and their relatives gave positive feedback about the kind and caring nature of the staff team. Staff knew people well and a friendly and more relaxed atmosphere was evident. People thought they were listened to and were involved in their care and how this was delivered.

A greater emphasis was placed on meaningful activity. People's interests were taken into account and catered for on an individual basis. During this inspection, people were not left unattended for long periods of time.

Staff had a good understanding of their responsibilities in raising concerns of a safeguarding nature. Staff felt the management team would listen to and act on any concerns they had, however, they knew how to tell organisations outside of the service if this was necessary.

The food provided was of good quality and people were happy with the meals and menu choices. Specific dietary needs were catered for and communicated to the kitchen staff.

People and their relatives were given opportunities to give their views of the service through meetings. People told us they were listened to and their views were taken into account.

Positive feedback was extended from people, their relatives and staff about the new manager and their management and leadership skills.

The service was clean and odour free. All maintenance of the premises and servicing of equipment was undertaken when necessary by the appropriate professional bodies.

The provider had now displayed the ratings from the last inspection in July 2017 in a prominent place so that people and their visitors were able to see them.

During this inspection we found three breaches of the Health and Social Care Act 2008 (Regulated Activities) Regulations. You can see what action we told the provider to take at the back of the full version of this report.

The five questions we ask about services and what we found

We always ask the following five questions of services.

Is the service safe?

Requires Improvement

The service was not consistently safe.

Medicines were not always well managed to provide a safe service.

The processes used to determine the levels and skills of staff required to provide people's assessed needs was not used effectively. The provider did not follow robust recruitment practices.

Individual risk assessments had improved and they now provided the detail necessary to prevent harm.

Management and staff had a good understanding of how to keep people safe from abuse and their responsibilities to report any concerns.

Is the service effective?

Requires Improvement

The service was not consistently effective.

Staff did not always receive the training to make sure they had the skills and knowledge to provide the support people in their care were assessed as needing. Staff did have the opportunity to have one to one supervision meetings with their line manager.

Further improvements were required to ensure people's basic rights were upheld in relation to the Mental Capacity Act 2005.

Care plans were in place to provide the information required for staff to provide person centred care and support.

Some adjustment was required to a malnutrition assessment tool. Peoples nutrition and hydration were planned and catered for. People had access to advice and guidance from health care professionals.

Is the service caring?

Requires Improvement

The service was not consistently caring.

People told us their privacy was respected. Transferring information in care plans into practice to maintain people's dignity required some improvement.

People and their relatives thought the staff were kind and caring in their approach.

The service had a more relaxed and happy atmosphere and staff knew people well.

Is the service responsive?

Requires Improvement

The service was not consistently responsive.

People's cultural needs were addressed in care planning, however more work needed to be done to ensure people were supported in practice. People and their relatives were asked what their wishes were at the end stages of their life.

More personalised care plans were now evident.

More opportunities were available for people to engage in activities on a daily basis.

People and their relatives knew how to complain and information was provided how to make a complaint.

Is the service well-led?

Requires Improvement

The service was not consistently well led.

Although the provider and manager had made improvements, further development was required to expand on this and evidence sustainability.

Quality audit systems were now more effective in identifying areas for improvement, although these were still in early stages so needed to embed and show improvement over a longer period.

Many positive comments were received about the new manager of the service from people, their relatives and staff. The manager had developed a more open culture which was having a positive effect on the service.

People, their relatives and staff were asked their views of the service and opportunities were given to make suggestions for improvement.

Ashley Down Nursing Home

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014. The service was in special measures and we carried out this inspection to check they had made the required improvements.

This inspection took place on 20 and 21 February 2018. The first day of the inspection was unannounced. The inspection was carried out by one inspector, a specialist nurse advisor and an expert by experience who has experience of family members living in a care home. An expert by experience is a person who has personal experience of using or caring for someone who uses this type of care service.

Before the inspection, we asked the provider to complete a Provider Information Return (PIR). This is a form that asks the provider to give some key information about the service, what the service does well and improvements they plan to make. We looked at notifications about important events that had taken place in the service which the provider is required to tell us by law. We used this information to help us plan our inspection.

We spoke with three people who lived at the service and two relatives, to gain their views and experience of the service provided. Many people living in the service were not always able to articulate their views, had a poor memory or were too ill. We used the Short Observational Framework for Inspection (SOFI). SOFI is a way of observing care to help us understand the experience of people who could not talk with us. We also spoke to the registered provider, the new manager, one nurse and one agency nurse and three staff.

We spent time in the communal areas observing the care and support provided and the interaction between staff and people. We looked at seven people's care files, medicine administration records, staff records including two staff recruitment records, four staff supervision records as well as five staff training records, the staff rota and staff team meeting minutes. We spent time looking at the provider's records such as;

policies and procedures, auditing and monitoring systems, complaints and incident and accident recording systems. We also looked at residents and relatives meeting minutes and surveys.

Requires Improvement

Our findings

At our last inspection, on 4 and 7 July 2017 we found that the registered provider was in breach of Regulations 12, 18 and 19 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. These were in relation to, appropriate action was not taken to identify and reduce risks to individual's safety and welfare; staff were not protected from risks to their health and welfare; people who displayed behaviour that others found challenging and harmful were not supported appropriately by staff who had the training necessary to manage the risks and prevent harm; staff were not deployed appropriately to provide the care and support people had been assessed as requiring; people were left for long periods of time unattended; safe recruitment practices were not followed.

At this inspection we found improvements had been made to, the management of individual risk and the management of behaviours that challenge. People were no longer left for long periods of time unattended. Some improvements had been made in relation to staff deployment and safer recruitment processes, however, further improvement was needed.

The people who were able to tell us about their care told us they felt safe. The comments we received included, "I feel safe living here, the permanent staff are always friendly. Always having a laugh and joke with them"; "I would prefer to be in my own home but could no longer cope, but this is perfect for me, I have lovely staff here to help me" and "I feel safe. Staff are always under pressure of time when they help me out".

Relatives also felt safe with the care provided to their loved ones. One relative said, "[Relative] was distressed at leaving his home. The girls (staff) helped him to settle in quickly, they (staff) were keen to learn about his personality so they could make the move run smoothly. He's happy and we are happy with the care he is getting". Another relative told us, "Yes he is very safe, I couldn't wish for anything better for him. Staff are very kind and caring to [Relative]".

Although suitable numbers of staff were available to provide the care and support to the numbers of people living in the service at the time of inspection, the assessment used to determine staffing levels was still not used appropriately. The provider employed housekeeping staff to provide the cleaning services, one housekeeper was on duty each day. One cook was on duty each day to prepare and cook the meals. This meant nursing and care staff could concentrate on providing care and support to people as they were not required to carry out cleaning and cooking duties. The new manager told us they were short of registered nurses and care staff and were in the process of trying to recruit to both. In the meantime, the provider used agency nurses to cover any shortfalls in the rota. They said they relied on the same agencies and tried to

engage the same agency staff to provide consistency. A member of staff told us, "We are short staffed and it is more difficult with agency nurses as they don't know the home and we have different agency at times. Our own nurses are good though". The provider had introduced a new dependency tool in order to assess the care needs of each person and ensure the staffing levels matched the needs of people living in the service. The new dependency tool was not being used any more effectively than the tool in use at the last inspection in July 2017. A dependency assessment was carried out for each person with a numbered score for each area of need. The scores had been added to make a total score. The total scores placed people into one of four categories of need, standard care; nursing needs; enhanced nursing/care needs or complex needs. However, no further assessment was undertaken to determine how to check the level of staffing required to meet those needs. People assessed as having standard care needs required less staff care and support as those assessed as having complex needs. Therefore if all the people living in the service were assessed as needing standard care, less staffing and a different skill mix of staff would be required than if every person had been assessed as requiring complex care. We asked the new manager about this and they said they used the score to be able to request extra funding if necessary. The new manager told us the dependency assessments were reviewed every six months. This would not continuously determine the levels of assessed needs in the service to monitor the correct staffing levels and the appropriate skills of staff to provide the care required.

The failure to demonstrate that staffing levels were based on individual needs and were responsive to people's changing needs is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Some improvements had been made to the recruitment processes since the last inspection in July 2017. However, further improvement was needed to make sure only suitable staff were employed to work with the people living in the service. There was no evidence that applicants had been interviewed prior to being offered a position. We asked the manager about this and they were unable to find any interview notes for the staff whose recruitment files we looked at. Although the registered manager had received references for one staff member, the dates of employment given by their previous employers did not correspond with the information given by the staff member on their application form. There was no evidence the registered manager had questioned this. The same staff member had not been asked to supply proof of their address. This meant the registered manager had not followed up on anomalies within the recruitment process to ensure only suitable staff were employed to work with people living in the service who may need safeguarding.

The failure to ensure all necessary checks are carried out and followed up to ensure only suitable staff are employed to care for people living in the service is a breach of Regulation 19 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The registered manager had made checks against the Disclosure and Barring Service (DBS). This highlighted any issues there may be about staff having criminal convictions or if they were barred from working with people who needed safeguarding. Application forms were completed by potential new staff.

The ordering, storage and returns of medicines were well planned and documented. However, the containers used to store and return medicines no longer required was not adequate. The lid did not fit properly and was therefore not tamper proof. This meant that medicines could be removed and not be noticed creating safety concerns. Medicines administration records (MAR) were neat and legible which meant errors were more easily identified. People had an individual care plan and a risk assessment to address the support required with the administration of their medicines. There was no guidance in place for staff to follow when people were prescribed 'as and when necessary' (PRN) medicines. Guidance is

necessary to enable the nurses administering the medicines to know what the PRN medicine was prescribed for, when to offer it and how often the person could safely take the medicine. The senior nurse told us they were planning to start using PRN guidance from 26 February 2018. One person was unable to verbally communicate when they were in pain. The person's care plan stated a recognised pain assessment tool should be used to check if the person was experiencing pain. An agency nurse was administering medicines and used the tool to decide if the person required PRN pain relief. They assessed the person using the tool and made the initial decision the person did not require pain relief. A permanent nurse who was not on shift but supernumerary (not counted in the numbers of staff on shift) that day and knew the person well, reassessed the person and the initial decision not to administer pain relief was changed. As it was the agency nurse's third shift in the service, they did not know the person as well as the permanent nurse. However, it would suggest that further guidance was necessary to support agency or new nurses when using the assessment tools adopted by the service to inform their decision making to ensure people's needs were met.

Although medicines audits were undertaken, these did not include a daily or weekly check of medicine stock levels to ensure people received their medicines as prescribed. This meant that stock may become low and the registered manager and nurses would be unaware. Mistakes could be made and these would go unnoticed, for example, people may have been given more medicines than prescribed or not enough. Although most of the medicines were issued from the pharmacist in blister packs, some medicines were not in the blister packs and arrived in medicine boxes. The senior nurse told us they had plans to start monitoring stock levels on 26 February 2018.

The failure to ensure consistent safe management of prescribed medicines is a breach of Regulation 12 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

People told us nurses were responsive to their needs if they were in pain. One person told us, "The nurse is good at giving me tablets for my pain. She stays with me until I have taken them". A relative said, "When I am here I notice that the nurse always stays with him to make sure he has taken his medicine. He was in pain and the nurse asked the doctor to see him and was able to change his medication. He appears a lot happier now".

One person chose to take a range of homely and herbal remedies. All these remedies were well documented by nurses and stored in the person's own room under lock and key for safety. The person liked to take their remedies at specific times which sometimes fell outside of the normal medicines administration round, however, nursing staff supported the person's choices and made sure they planned accordingly.

Pressure area care and would care was generally managed well, however there were concerns about one person's wound. The person had a severe skin infection on their leg which had resulted in an extensive open wound.The wound had deteriorated on 19 February 2018. The senior nurse had reported to the GP on 15 February 2018 who had diagnosed cellulitis and prescribed a course of antibiotics. Although the person was on a course of antibiotics, the GP visit had been prior to the wound breaking down significantly. Nurses were dressing the wound, following their own care plan. The person had not been referred to any other healthcare professional since the deterioration. This meant the person may not have been receiving the most appropriate treatment. The senior nurse contacted the GP who visited the person on the second day of the inspection and a plan was put in place for a hospital referral if no improvement was made within a week. The wound was described in detail within the care plan. We asked if the wound had been photographed in order to show its progression and to evidence the extent of the deterioration to the GP or a wound specialist. The nurses told us they would normally take photographs each time the wound was dressed, however, the camera they had used had not been working for the last two months. They told us they had requested a new

camera from the provider on more than one occasion, however this had not been supplied. The provider told us they did have a new camera which was in their car. The camera was installed in the service on the first day of inspection. The nurses told us they would now start keeping a photographic record.

The assessment of individual risk had been improved since the last inspection in July 2017. Risks had been identified and steps put in place to keep people safe and prevent harm. The risk of pain had been assessed for people who were unable to verbally communicate their pain levels. Moving and handling risk assessments provided the detail to support people to move from one area to another safely. For example, people who required the use of a hoist to move from their bed to a chair or wheelchair and vice versa. The size and type of hoist needed was clearly described and the serial number of the specific hoist sling used for the individual was recorded. This made sure that staff always used the correct sling and size and prevented cross infection by not using the same sling for more than one person. Where people were at risk of falls, the risk had been assessed with guidance provided for staff how to keep people safe and prevent further falls. People were supported to remain safe by the appropriate management of individual risks.

Where people were at risk of malnutrition or dehydration, food and fluid charts were in place to record and monitor their intake. People who were nursed in bed or had difficulty moving independently had their position changed regularly. Staff recorded the position changes to prevent the risk of their skin breaking down due to prolonged pressure in one area. People had pressure relieving mattresses and these were checked regularly to make sure they were working appropriately and remained on the correct and individual setting to give the maximum protection.

People had been assessed as requiring staff support to evacuate the building if a fire broke out or some other emergency situation developed. People had an individual personal emergency evacuation plan (PEEP) in place. A PEEP sets out the specific physical, communication and equipment requirements that each person has to ensure they could be safely evacuated from the service in the event of a fire. PEEP's had been improved since the last inspection in July 2017 and now gave clear instruction and guidance to enable staff to safely support people to evacuate the building.

People who were able to use their call bells had them close to hand so they were able to use them to request assistance if they needed to. One person told us, "I get everything I need from the staff. If I need some help I just press the buzzer and they come straight away". Those who could not use a call bell were checked regularly by staff and this was recorded in their care plan.

Staff had a good understanding of what constitutes abuse and of their responsibilities in reporting any concerns. Staff were confident they would be listened to and the new manager would act on any concerns raised with them. One staff member said, "[The new manager] has told us they would not tolerate loud voices or arguments in the home". However, they knew they could report outside of the service if they felt they were not being listened to. One person told us they were not happy with how an agency staff member had approached them the day before. They did not want the agency staff member to assist them again. They told us the new manager had spoken to them, talking through their concerns. The registered manager had made appropriate referrals to the local authority safeguarding team when necessary. One recent incident had been reported and the registered manager was seen to have taken action promptly, carrying out an investigation and reporting the outcome.

Accidents and incidents had been recorded by staff on the appropriate forms to show the detail of the incident and the action taken. The new manager had started to complete an analysis of incidents each month including an analysis of falls. They checked the areas where people had fallen, such as their bedroom, for any hazards or reasons why the fall may have happened. They identified that one person did

not always use their call bell when they wanted to move to another part of their room, despite being reminded. The manager ordered an alarm mat so staff would be alerted if the person stepped onto it, which meant staff could respond and assist the person to make sure they remained safe.

All areas of the service were clean and smelled fresh. No hazards were observed in the communal areas and corridors, such as hoists and wheelchairs. Doors to cleaning cupboards and sluice rooms were kept locked so people were not at risk of coming into contact with harmful substances or equipment.

Servicing of equipment and utilities such as gas safety, electrical installations, portable electrical appliances and hoists were carried out at regular intervals by the appropriate professional services. Fire safety servicing such as fire alarm systems and fire extinguishers were serviced and maintained by trained technicians.

Requires Improvement

Our findings

At our last inspection, on 4 and 7 July 2017 we found that the registered provider was in breach of Regulation 11 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was in relation to ensuring compliance with the requirements of the Mental Capacity Act 2005 (MCA 2005) and ensuring people basic rights were upheld. We also made a recommendation in relation to ensuring the continued professional development of registered nurses employed by the provider.

At this inspection, we found that improvements had been made to ensuring people's rights were upheld under the principles of the MCA 2005. However, further improvement was needed. Registered nurses continued to need more support with maintaining their ongoing professional development. We found that evidence that staff had completed mandatory training was not available.

The evidence was not clear that staff had received the training necessary to successfully carry out their role. Some training certificates were available in staff files, however many were out of date and some mandatory training certificates were not available at all. For example, out of the five staff training files we looked at, two had undertaken MCA 2005 training in 2013 and the certificate stated the training was valid for one year only. No further certificates were evident. The remaining three training files did not have any certificates to show the staff had received MCA 2005 training. Training certificates to show that some staff had received training in safeguarding vulnerable adults or fire training were also not available. One member of staff who had been in employment since November 2017 had not received any mandatory training to ensure they had the skills to provide care and support to people. No care staff had completed a catheter care course even though they were responsible for providing the personal care of people who had a catheter in situ. Staff had not had the opportunity to undertake the care certificate or the Qualifications and Credit Framework (QCF) to evidence their knowledge and skills and to prepare them for further development in the sector. The Care Certificate and QCF are agreed sets of standards that sets out the knowledge, skills and behaviours expected of specific job roles in the health and social care sectors. The new manager told us they planned to commence both these vital opportunities for staff although this had not yet started. The induction of new staff was also an area the new manager had identified as needing further improvement. They told us they had recognised new staff had not had a robust induction and planned a more formal approach to ensure staff understood what was expected of them in their role and to support them to achieve.

Registered nurses had not been given the opportunity to engage in continuing professional development to update their skills and training to support them to keep their registration intact. Out of three nurses, two had completed a course to update their skills in the technique of catheterisation. Two nurses had completed a

catheter care course. We spoke to the manager about supporting the registered nurses professional development. They told us they had spoken to the provider about this and they intended to commence a competency based training for nurses. However, this had not yet been sourced or commenced. We made a recommendation about the professional development of nurses at the last inspection in July 2017.

The failure to demonstrate that staff had received the training and development required to provide the care and support people were assessed as needing is a breach of Regulation 18 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The people who were able to speak with us told us they made decisions about their care. The comments we received included, "Staff always ask before they do anything for me. I don't like bossy people. I tell staff what I want to do and when I need their help"; "I have a shower once a week and if I ask they will wash my hair for me. They ask me what help I want. I wash my face and they do the rest for me" and "I let staff know if I want to get out of bed. I sometimes sit in the chair or go downstairs if there is something on. Today I wanted to stay in bed, it is more comfortable for my back. The staff let me decide what suits me". A relative also told us their loved one was encouraged to make their own choices about their care. The relative said, "[Relative's name] decides what he wants to do. He decided not to let the carers wash his hair, they didn't force him. He is very fond of [Name manager] and [Name nurse] and they have been able to coax him into having his hair washed".

The MCA 2005 provides a legal framework for making particular decisions on behalf of people who may lack the mental capacity to do so for themselves. The Act requires that as far as possible people make their own decisions and are helped to do so when needed. When they lack mental capacity to take particular decisions, any made on their behalf must be in their best interests and as least restrictive as possible. Improvements had been made to the processes to assess people's capacity to make particular decisions where this was in doubt. Mental capacity assessments had been carried out appropriately for different decisions such as for staff to administer medicines, to receive assistance with personal care, assistance with eating and drinking and the use of equipment such as a hoist or bed rails. Records had been kept to show decisions had been made in people's best interests. Important people in the person's life had been included such as relatives or friends. However, some mental capacity assessments had been completed on different dates to when best interest's decisions had been taken. For example, one person's capacity assessment to determine if they had the capacity to consent to receiving their medicines from staff was dated 1 February 2017 and a meeting to agree if it was in the person's best interests for staff to administer medicines was not completed until 27 November 2017.

Some staff did not have a good understanding of the MCA 2005 and the associated DoLS processes. For example, staff did not know if people in their care were subject to a DoLS authorisation, restricting their movements. Staff could speak about the basic principles of choice and how they would support people to make a choice or decision. However, they were not able to apply this to people's rights within the MCA 2005. Training certificates were not available to evidence that staff had received updated training in the MCA 2005.

This is an area we identified as needing further improvement.

Improvements had been made in ensuring the evidence was available to show the legal status of friends and relatives acting to make decisions on people's behalf. The new manager had asked relatives and friends who claimed to have Lasting Power of Attorney (LPA) to provide the evidence to show this. This meant that people's rights under the principles of the MCA 2005 were upheld as only people who were legally entitled to do so acted on people's behalf. A LPA is a way of giving someone you trust the legal authority to make

decisions on your behalf if you lose mental capacity at some point in the future, or if you no longer want to make decisions for yourself. There are two types of LPA; an LPA for financial decisions and an LPA for health and care decisions. Therefore if a person had agreed for a relative or friend to make only financial decisions on their behalf, that person would not be able to make decisions regarding their loved ones health or care arrangements. This would not mean the people who knew the person best could not be involved in the best interests decision making process.

People who lack mental capacity to consent to arrangements for necessary care or treatment can only be deprived of their liberty when this is in their best interests and legally authorised under the MCA. The procedures for this in care homes and hospitals are called the Deprivation of Liberty Safeguards (DoLS). The manager understood their responsibilities in making sure people's rights were upheld. Appropriate DoLS applications to the supervising authority had been made and kept under review.

People's care plans now included personalised information on all aspects of their physical, mental, emotional and social needs. Each care plan showed details of how to support people including, dementia and mental capacity; activities; cultural and spiritual; communication; behaviour that challenges; pain; medication; nutrition and hydration; personal care; pressure area care and risk of falls. One person was unable to voice their needs through speaking. Their communication care plan described how staff could best support them by checking their body language and facial expressions. The care plan went on to say that although the person often made sounds, if they were shouting out or appeared agitated, staff must check to see if they had pain, were hungry or thirsty or needed to go to the toilet. Where people were at risk of pressure sores due to not being able to move around freely, body maps were included in the care plan to show the areas on the body most at risk. The care plan went on to describe the care the individual needed to maintain their skin integrity. One person had experienced many periods in their life where they had been low in mood, affecting their day to day life at these times. This continued to be a factor. A good description of how they presented at these times was recorded with guidance for staff how they could help the person to cope during those times. For example, to encourage the person to talk about how they were feeling. The new manager told us they had included the review of care plans amongst their priorities since taking the position of manager in November 2017. They felt they had made progress although there was still work to do to further improve and to embed the full use of care planning in the service.

Records of referrals to and visits by health care professionals were now better evidenced since the last inspection in July 2017. Records were made of visits and telephone calls by the GP and visits by the dietician, specialist hospice nurses or district nurses.

One person had type 2 diabetes and required their blood glucose checking each week to monitor the stability of their diabetes. Although the blood glucose was checked and recorded each week, their levels were often on the high side. The times the reading was taken varied throughout the day and the care plan did not record a specific time. Blood sugar levels could be different dependent on, for example, if the person had just eaten or had not eaten for some time. This meant the records may not show an accurate record to pass on to health care professionals responsible for treatment and prescribing medicines.

We recommend the provider uses and follows nationally recognised guidance to ensure the efficacy of blood glucose readings in diabetes.

People's specific nutritional and hydration needs were assessed and recorded in the care plan to give staff the information they needed to make sure people's health was maintained. People's favourite food and drinks were recorded and those foods they did not like. This helped staff to encourage eating and drinking if people were reluctant and were no longer able to express their preferences. One person's care plan

recorded they needed assistance with eating and drinking. It showed they liked to drink out of a small tea cup for hot drinks and a small glass for cold drinks. We saw nurses assisting the person to have a drink in the way they liked as described in their care plan. Some people required a soft or pureed diet and this was clearly recorded in their care plan. A recognised assessment tool to check if people were at risk of malnutrition was used and reviewed regularly. Nurses had not always used the assessment tool correctly. Nurses had assessed a score of two when using the tool for one person at risk of malnutrition. However, nurses had not taken into account that the person had lost 3.1kgs over the last 3-6 months. This in itself was not unexpected due to the deterioration in the person's general health. However, a loss such as this should add one more point to the score, therefore their score should have been three. Where necessary, referrals had been made to a dietician to gain advice and guidance to maintain people's health and well-being.

We recommend the provider gains advice and guidance from a recognised source in using the universal assessment tool appropriately and to its full advantage.

The people who could speak with us told us they enjoyed the food provided. The comments we received included, "The food not bad. It's tasty, always plenty of it. If they have chicken casserole on the menu I ask for an alternative like a pie. It's not a problem for the cook. I'll have a mousse or a piece of fruit if there is pudding, it has too much sugar in it for me" and "The food varies so much, generally okay. I always get enough to eat". Only two people ate their meals in the dining room. This was down to choice or due to people's frail health condition. Both people in the dining room required assistance to eat their meal. Some people who ate in their room also required assistance. People were given time to eat at their own pace without rushing. Seven people needed to have their food pureed. Their meal was well presented with each element of food separated to create a meal that looked appetising.

The new manager told us one of their priorities since taking up their role was to make sure all staff received one to one supervision and to provide coaching sessions in the areas they felt needed improvement. They told us they had made it clear to staff from the outset that improvements needed to be made in the service. The new manager said they were also giving priority to the confidence and on-going skills of the registered nurses. Staff had received one to one supervision with their line manager, either the registered manager, the new manager or the senior nurse, on a regular basis. Supervision is a process, usually a meeting, by which an organisation provides guidance and support to staff. The new manager had developed an action plan with details of concerns discussed at individual one to one supervision meetings, the action expected of the staff member and the action to be taken by the manager. For example the new manager had recorded, if staff were asked to complete a training course or if their record keeping needed to improve. There were clearer lines of responsibility and the expectations of the staff team since the last inspection in July 2017.

Requires Improvement

Our findings

At our last inspection on 4 and 7 July 2017 we found that the registered provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was in relation to, people were not provided with appropriate opportunities to make decisions about their care; people did not have care plans that reflected their preferences and wishes.

At this inspection, we found that improvements had been made and people's preferences and wishes were now written into care plans and taken into account.

People and their relatives described the staff as kind and caring and always cheerful when carrying out their duties. People told us, "Staff are very caring and happy. If I am in a grumpy mood the staff will tease me out of it. They come in and talk and have a bit of banter with me. The male nurse here is always laughing"; "Staff are always in good humour, never grumpy, I get a kiss now and again, they are all lovely, very caring" and "Of course they are caring. If I need them they are there".

One relative said, "Staff genuinely care. When he is feeling down the staff make extra time to sit and talk to him" and another relative told us, "I have never met such caring people. If I get emotional, they are very kind to me and sit and talk to me. They keep me informed every step of the way".

One person who was living with dementia spent time sitting in the lounge area regularly lifted their blouse to wipe their mouth. This meant they fully revealed their bare upper body a number of times as they did not have undergarments on to preserve their dignity. The person was sitting in the middle of the lounge facing the TV. Behind the TV was a large bay window the full width of the room which looked out over a small area of garden and beyond that a pedestrian pathway and main road. No net curtains or blinds were in place on the windows. This meant members of the public passing the home may have been able to look in to see the person in a position that did not protect their privacy and dignity. The person's care plan did record that they did not like their mouth to be damp or to have food around their mouth and would use any available material to wipe their mouth, including their clothing. Staff were guided in the care plan to ensure they used a soft apron when assisting with drinks and food to ensure the person was able to wipe their mouth easily and comfortably with this. However, staff had not used the information in the care plan to ensure the person had appropriate underclothes on that protected their privacy and dignity at all times. This meant the person's assessed needs were not fully met at all times.

At other times, staff made sure they maintained people's privacy and dignity. People told us that staff always

knocked on their door and spoke before they came in. We saw that staff always knocked on doors before they entered even if the door was wide open. One person said, "The staff always knock and wait for me to say come in. I have my back to the door and they know I like to know who it is" and another person told us, " I always have my door open, the staff always knock and say my name as they come in". One person told us how their dignity was respected, "When I go for a shower I am always covered up". A relative commented, "He likes having the door open, if he is sleepy and wants to lie down they close the door for him so he is not disturbed and he gets some privacy".

Many bedrooms held few personal items belonging to people to reflect the individual's personality and preferences. Some had photographs of loved ones but others did not. Some bedrooms had bare walls and nothing on show to suggest the room was in use and was in fact the home of a person. A homely atmosphere was not always apparent.

People and their relatives were asked to provide information about their likes, dislikes and their wishes for their care. One person told us, "They know I prefer a bath to a shower and if I want one here I ask. There is a chair to lift me into the bath". Another person commented, "All the staff know my likes and dislikes. I soon tell them if I don't like something. The activity person has asked me about my family, what I liked to do and what I have done over the years". One relative said, "Staff are always asking us, the family, about him and how he likes to be cared for. We have put up photos of the family and we know the staff talks to him about us. They are very interested in him and his welfare. Keen to make sure he is comfortable".

There was jovial banter between staff and people and when staff left people's rooms they left with a cheery goodbye saying 'see you soon'. Staff were speaking to people in affectionate terms often getting a smile or an affectionate response back. One person who was nursed in bed held their hand out for staff to hold while they chatted. One person liked to have a kiss on their head and staff obliged by teasing them and saying, "I suppose you are waiting for your kiss".

Staff communicated with people who were sitting in the lounge by bending down or sitting beside them so they had eye level contact. Staff waited for people's responses before doing anything for them.

Relatives told us their loved ones always looked well cared for. One relative said, "When I visit I have never once found him looking uncared for. He is spotlessly clean and well looked after". Another relative commented, "He is treated like a person, not talked down to. Yesterday he was sleepy, I didn't want to wake him up. Staff allowed him to sleep".

Requires Improvement

Our findings

At our last inspection on 4 and 7 July 2017 we found that the registered provider was in breach of Regulation 9 of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was in relation to, people did not have personalised care plans that ensured their care was provided in a way that met their individual needs; people did not have their social needs met placing them at risk of social isolation; care plans were not reviewed to reflect changes in people's care needs.

At this inspection we found improvements had been made. People's care plans contained more personalised information in order for all their needs to be met and care plans were reviewed regularly. A greater emphasis was placed on ensuring people's social needs were met and people had more opportunities for stimulation. Further improvement was needed to embed the person centred approach in care planning into practice.

Personal information including people's life history was now included in their care planning information to provide a more person centred approach to their care. This included, who was important to the person; where they had lived; their siblings and children's names and any factors in their life that were important to share with staff. Although more personal information was now being introduced into people's care plans to enable staff to provide care and support that matched people's wishes and preferences, embedding this into the day to day approach of staff was still in progress. Two people had been sitting in the lounge through the day on both days of inspection. One person who was not able to verbally comment was taken to bed at 15.30 and the other person was asked if they wanted to go to bed at that time but they said no on the first day. On the second day the person who did not verbally communicate was taken to bed at 14.30. From 14.30 the other person was asked four times by care staff if they wanted to go to bed and each time they were asked they said no, until 15.30 when they said yes. This suggested that staff were working to a routine rather than the personal preferences of people.

People's care plans included their cultural and spiritual needs. This area was not always fully developed to ensure people's needs were met, with assumptions made for some people. One person's care plan stated their religion was Church of England but that due to advanced dementia they did not practice their religion. It was not clear if they had previously practiced and gained solace from their religion. No guidance was given to show how staff could support the person to address their individual religious and cultural needs despite living with dementia. Instead, the care plan stated that staff should continue to try to engage the person in cultural activity, 'such as bonfire night, St George's day and Xmas day'. There was no evidence that these activities addressed the cultural needs of the individual.

People's care plans were reviewed regularly by registered nurses or the new manager. Although care plans were now written in a more person centred way, including more detail about each individual, it was not always clear that people were involved in developing or reviewing their care plan. There was no evidence to show that one person who was clearly able to give their views and opinions had been involved in their care plan. There was no evidence to show if people were not able to participate in developing or reviewing their care plan and what other methods were used to gain relevant information.

Some people required specific care as they were nearing the end stages of their life. This was recorded in their care plan. A specialist hospice nursing team visited people and kept in touch with staff by telephone to discuss the interventions and changes required to people's care plans. People's relatives were involved in the care plan where appropriate which helped to ensure that people's wishes were taken into account even if they were not able to voice this themselves. One relative told us, "The family have had discussions with the hospice, doctors and the home about his future care with [relative name] present".

People were happy with the activity opportunities available to them. The comments we received included, "The activities person pops in every day and we have a chat and a laugh. I don't like group activities, I prefer to stay in my room, I have got my videos. I would like to go out but need someone to come with me to make sure I am using my wheelchair properly. Staff are too busy to come with me"; "They often have music and singing in the afternoons. If I want to go down and join in the staff take me down. If I am spending time in bed [The activities coordinator name] comes up to see me. She paints my nails for me" and "[The activities coordinator name] regularly comes in. I am expecting her this afternoon. If I want she will put my phone on charge. We will have a chat".

Most people were either cared for in bed or chose to stay in their room. This meant only two people accessed the communal lounge area throughout the day. The activities coordinator spent a lot of their time in the lounge engaging with the people sitting there. They read the daily newspaper to one person as well as a local newspaper later in the day, discussing the local news and asking the person their views and thoughts of what they were reading. The other person did not appear to understand the newspaper discussions or what was on the TV, however, they were included in the conversations and discussions. The nurse on duty was also a regular presence in the lounge area whenever the activities coordinator went out of the room. However, care staff did not spend time with people in the lounge, instead passing through when required. Staff told us they would like to have more time to spend sitting and chatting with people.

One person's care plan stated they preferred one to one activities rather than as part of a group. One of the activities they enjoyed was hand massage. We saw the activities coordinator providing hand massage to the person and quietly chatting at the same time. Even though the person was not able to chat back it was clear they were enjoying the intervention. The same person's care plan stated they liked to listen to music, however, there was no music on in the lounge, instead the winter Olympics was playing on the TV throughout most of the first day of inspection.

The details of activities through the week were displayed in the hall and lounge along with planned activities for the next few months. As most people spent time in their rooms the morning activities were focused on one to one sessions with people. The activities coordinator recorded all activities undertaken with people within an activities folder where individual records were made. A brief one page life history was included in the activities folder, recording their family history, what they liked to do now and the things they had enjoyed in the past. The activities coordinator told us that the one to one sessions were driven by each person's wishes. One person liked them to sit and read the adverts to them, another person liked to read the newspaper and they would talk about the day's news or chat about their family or grandchildren. Another person had shopping delivered to the service and the activities coordinator would put the shopping away

for the person.

The provider's complaints policy was displayed within the reception area so that people and their relatives could access a copy if they wished. Only one complaint had been received since the last inspection. Records showed this had been investigated thoroughly and the complainant had been responded to appropriately with the outcome of the investigation.

Requires Improvement

Our findings

At our last inspection on 4 and 7 July 2017 we found that the registered provider was in breach of Regulations 17 and 20A of the Health and Social Care Act 2008 (regulated activities) Regulations 2014. This was in relation to, the service was not managed in a way that delivered consistent safe and effective care to people; effective governance systems were not in operation and had not identified shortfalls in the quality and safety of the service; accurate records were not kept for the purpose of running the service; the views of people and their relatives were not taken into account; the management, leadership and oversight of the service; the provider had not displayed the rating of their previous CQC inspection in a prominent place as required.

At this inspection we found improvements had been made as shown throughout this report. A new manager had been employed since the last inspection. They had made positive improvements since taking up their new position. However, further improvements were needed through sustained management and leadership to ensure the continued quality and safety of the service. The provider had displayed the ratings of the CQC inspection in July 2017 in a prominent place in the reception area.

People and their relatives told us they felt they were listened to and their views were taken into account. One person said, "They definitely listen. I like the new manager, they are prepared to come along and see me in my room and discuss any issues" and another person told us, "I kicked up about the old pictures in my room, the owner came and saw me and asked what I would like. I have now got new pictures to look at". One relative said, "We are very happy with the home. He is happy and content so we are happy". Another relative commented, "They keep me informed every step of the way. I can ring up at any time and they will tell me how he is".

A new manager was now in post, since November 2017. Although they were not yet registered with CQC, they had made an application and this was in progress. The provider told us they were in the process of cancelling their registration and planned to take a back seat once the new manager had successfully registered with CQC. People and their relatives had positive comments to make about the new manager. People said, "[Manager's name] is always walking about, when she is passing she pops in to see me and ask how I am. She is a very happy person" and "It is easy to talk to the manager. I just ask one of the staff to ask the manager to come and speak to me". Relatives found the new manager to be approachable. One relative said, "[Manager's name] seems to know what she is doing. We find her easy to chat to. [My relative] is very fond of the new manager and [Nurse's name]" and another relative told us, "The manager is easy to talk to, I am kept fully informed of how [Relative name] is doing".

The staff we spoke with were positive about the new manager and the improvements started since they came in to post. Staff said they were encouraged to read people's care plans when this was not something they had been advised to do before. One staff member told us, "I did not know I should have been reading things, I was never told to do this. Now I read care plans whenever I have the time, such as in my break".

A range of audits were in place to monitor the quality and safety of the service provided and these were now starting to be used to better effect since December 2017 when the new manager came into post. However auditing was a work in progress as a more consistent approach had only been used over a two month period. The areas checked either weekly or monthly included, people's care plans; medicines management; infection control; complaints, accidents and incidents; falls; pressure area care and the new manager's walk around. The new manager completed an action plan attached to each audit where improvements were required. Auditing of people's care plans had been undertaken by the new manager in December 2017 when they had found areas for improvement in one person's care plan such as individual risk assessments, consent to care and treatment and person centred planning. An action plan had been developed by the new manager to address the areas identified. The new manager had also discussed the action plan with the nurse responsible for the upkeep of the person's care plan to ensure they understood what was expected of them and to relay positive comments where relevant. The new manager had started a 'walk around' where they checked the environment and making sure people were clean, well cared for and receiving the care expected. The walk around was in it's infancy as only two had been completed.

Regular staff meetings were held to provide updates to staff and share information. The items discussed at the staff meeting in December 2017 included, sharing the latest CQC and local authority reports, both of which showed improvements were required; the whole staff team's responsibility in making improvements; safeguarding vulnerable adults; accident and incident reporting. A coaching session was held by the new manager to ensure staff knew how to complete various records. At a staff meeting on 13 February 2018 the new manager had held a coaching session to test staff knowledge of their responsibilities in relation to safeguarding vulnerable adults and whistleblowing (telling someone). The new manager had produced an action plan to make sure decisions taken and action required following the staff meetings were followed through. A member of staff told us, "I like it here more now – we are not as tense" and, "It is now well managed, a lot has changed".

The provider and new manager held meetings with people to gain their views of the service provided and to provide updates and share information. At a meeting held in December 2017, if people were not able to attend the meeting in the communal lounge, the new manager visited each person in their room to share the information. The manager told people about the last CQC inspection report and the plans she had to make improvements. One person thanked the manager for their honesty. People shared their concerns about the amount of agency use due to staff shortages. The manager told people they were hoping to recruit two new care staff and one new nurse. People also said the food was 'plain' and the manager said they would look into this. Following the meeting the manager produced an action plan to show the actions agreed and when they would be completed by. For example, the manager had spoken to the staff agencies they used and requested they always sent the same staff who knew people well. The manager had also recorded that two staff had been recruited and were awaiting recruitment checks to be completed. People's views were now being taken into account to inform the running of the service.

Relatives meetings were also held. One meeting held in November gave the opportunity for the new manager to introduce themselves and chair an open discussion about the latest CQC report and a local authority visit where areas of improvement were also identified. The manager outlined their plans for involving relatives in people's care plans and reviews. The manager also provided information about the MCA 2005 and Lasting Power of Attorney and what this means in practice. People's relatives were given the

opportunity to have their say in the running of the service and provided with information to support their decisions.

It is a legal requirement that a provider's latest CQC inspection report rating is displayed at the service where a rating has been given. This is so that people, visitors and those seeking information about the service can be informed of our judgments. We found the provider had displayed a copy of their inspection report and ratings in the reception area.

Registered persons are required to notify CQC about events and incidents such as abuse, serious injuries and deaths without delay. Notifications had been received by CQC about important events that had occurred since the last inspection.

Action we have told the provider to take

The table below shows where regulations were not being met and we have asked the provider to send us a report that says what action they are going to take.We will check that this action is taken by the provider.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 12 HSCA RA Regulations 2014 Safe care and treatment The provider failed to ensure the consistent safe management of prescribed medicines.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 19 HSCA RA Regulations 2014 Fit and proper persons employed The provider failed to ensure all necessary checks were carried out and followed up to ensure only suitable staff were employed to care for people living in the service.

Regulated activity	Regulation
Accommodation for persons who require nursing or personal care	Regulation 18 HSCA RA Regulations 2014 Staffing The provider failed to demonstrate that staffing levels were based on individual needs and were responsive to people's changing needs. The provider failed to demonstrate that staff had received the training and development required to provide the care and support people were assessed as needing.